# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 887 Integrated Personal Care Administration

Provides support to Residential Care Facilities participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification. Resident assessment and determination of level of care service authorization, appropriateness of placement and monitoring of the quality of care.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $429,622 | $214,811 | $214,811 | Yes | $0 | 6.00 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment. Quality health care for Medicaid beneficiaries IPC Screening is an integral part of the service as negotiated with CMS in approving our state plan amendment. It provides the information that is the basis for determining the need for the service, the appropriateness of placement and to monitor the quality of care. The service will be authorized for those who need the service and problems with the quality of care will be addressed.

**Outcome Measures:**

1)There will be an increase in the number of participating facilities compared to 2003. 2) There will be an increase in the number of residents served compared to 2003. 3) There will be a decrease in the number of inappropriate admissions compared to 2003. 4)There will be an increase in the types of educational programs conducted compared to 2003. 5) The screening process will yield number screened and the number authorized to receive services.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 888 Clinic Services

Services designed to assist Medicaid recipients of any age and their families adapt to the chronic diagnosis of diabetes, learn disease management skills, adopt realistic dietary regimens and acquire information regarding the nature of diabetes. Genetics Education Services are directed at children who have disabilities and/or developmental delays for the purpose of identifying children with or at risk of genetic disorders. Only Rural Health Clinics, Federally Qualified Health Clinics, and children's coverage are considered mandatory. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $86,467,752 | $22,692,920 | $60,811,525 | Yes | $2,963,307 | 0.00 |

**Expected Results:**

Decrease in further medical care and hospitalization. Increase patient education and disease management to

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

improve quality of life.

**Outcome Measures:**

Decrease in diagnoses such as gangrene, kidney disease and hemodialysis to prevent loss of limbs and decrease hospitalizations due to secondary diagnosis of diabetes. Early detection of genetic disorders will enhance treatment modalities as well as increase beneficiary utilization. Coordination of services and care with public and private providers. Total Transactions - 1,085,692 Cost per Transaction - $79.13 Total Recipients - 194,891 Cost per Recipient - $441 SE Average Cost per Recipient - $684 Mandatory Eligibles 86.02% Optional Eligibles 13.98%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 889 Clinic Services Administration

(1) Support to providers including Outpatient Pediatric AIDS Clinics, End Stage Renal Disease Clinics, Infusion Centers, Ambulatory Surgical Centers, x-ray providers and laboratories through claims resolution & processing, policy development, interpretation &clarification, rate setting, and assisting with budget management. (2) Provide support and oversight to the Medically Fragile Children's Program (MFCP) which serves Medicaid eligible children with complex ongoing medical needs. This program provides a medical home with primary care services, care coordination, and case management services. It is currently offered in only two urban areas: Columbia and Greenville/Easley. (3) Provide support to providers of Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)to assist clients in need of reinforcement of the medical plan of care. Provide support to providers of Infant Home Visits.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $291,076 | $145,538 | $145,538 | Yes | $0 | 4.16 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment. Quality health care for Medicaid beneficiaries. Increase in quality of life and life span of MFCP beneficiaries through comprehensive, coordinated services. Increased compliance with medical treatment plan.

**Outcome Measures:**

Resolution of claims. 1,584 pieces of written correspondence. 1,860 provider/beneficiary telephone inquiries. Compared to children with similar medical challenges, MFCP has reduced Medicaid expenditures by over 50%.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 890 Durable Medical Equipment

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Reimburse providers for services. This is an optional service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $44,208,680 | $11,950,769 | $31,066,631 | Yes | $1,191,280 | 0.00 |

**Expected Results:**

Medicaid eligible persons have access to services.

**Outcome Measures:**

70,963 Beneficiaries served Cost per Recipient - $601 599,973 Items/Services provided Cost per Transaction - $71.05 Mandatory Eligibles 84.44% Optional Eligibles 15.56%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 891 Durable Medical Equipment Administration

Sets policies, procedures & guidelines for provision of durable medical equipment (DME) and supplies. Conducts prior authorization for equipment/services. Supports provider base through claims resolution & processing, policy development, interpretation &clarification.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $433,814 | $216,907 | $216,907 | Yes | $0 | 6.20 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment. Appropriate DME for Medicaid beneficiaries

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 892 Managed Care

Provide options for Medicaid coverage for enrolled beneficiaries in SC. The state reimburses the Managed Care Organizations (MCOs) an actuarially sound, capitated reimbursement rate for enrolled members. MCOs generally provide a coordinated system of primary care aimed at establishing beneficiaries in a medical home. Additionally, they provide

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

additional health services, such as health education, home visits, etc., in a coordinated fashion in order to increase healthcare outcomes and reduce unnecessary, higher cost services such as emergency room visits and hospitalizations. This is a mandatory service. 42CFR Part 438, State Law Title 44, 44-6-5 - 44-6-910

| FY 2004-05 | | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $62,997,327 | $16,893,160 | $44,240,789 | Yes | $1,863,378 | 0.00 |

**Expected Results:**

Cost savings through a reduction in the cost of avoidable care. Improved access to specialists and other Medicaid-sponsored services. Improved health status of the beneficiaries. Increase in beneficiaries with an established medical home.

**Outcome Measures:**

There are two additional Medicaid Managed Care programs establishing themselves in SC now; therefore, we anticipate the number of recipients being served through this type of program to increase during this fiscal year. Total Transactions - 631,427 Cost per Transaction - $112.70 Total Recipients - 78,002 Cost per Recipient - $912 SE Average Cost per Recipient - $1,680 Mandatory Eligibles 95.64% Optional Eligibles 4.36%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 893 Managed Care Administration

Provides oversight and support to current Medicaid Managed Care Organization (MCO). Provides technical assistance to MCOs wanting to operate in SC. Develops new managed care initiatives for Medicaid program. Partnership with private vendor to operate Disease Management program for beneficiaries with hypertension, diabetes, and asthma. 42CFR Part 438

| FY 2004-05 | | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $857,812 | $428,906 | $428,906 | Yes | $0 | 6.50 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment in a managed care-type program. Improve the healthcare services delivered to Medicaid beneficiaries through the provision of coordinated, supportive services aimed at improving health outcomes, quality of life for enrollees, and reduction in costly healthcare expenditures.

**Outcome Measures:**

Decrease in number of ER visits. Decrease in the pharmacy costs for PCCM beneficiaries. Anticipated decrease in overall health costs because of beneficiaries having a formal medical home and receiving intensive care coordination for chronic diseases.

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# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 894 DMH Medicaid Services

Provides financial support for community mental health treatment services to severely emotionally disturbed children and chronically mentally ill adults.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $221,723,921 | $0 | $154,940,676 | Yes | $66,783,245 | 0.00 |

**Expected Results:**

The development of an individualized plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance to enhance individual living skills and to help prevent children, adolescents and their families from being institutionalized or hospitalized Services emphasize the acquisition, development and expansion of rehabilitative skills needed to move forward in recovery, resulting in an improved quality of life for clients and their families.

**Outcome Measures:**

Improved functioning and safety for seriously emotionally disturbed children and for mentally ill adults. In addition to improving quality of life, this should lead to a reduction in the costs associated with the treatment of these conditions by increasing community tenure. The occurrence and severity of disabilities will be reduced where possible. Clients will function at an optimal level in the least restrictive level of care. Outcomes include a reduction in hospitalizations and emergency room visits for this population. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 1,373,199 Cost perTransaction - $124.79 Total Recipients - 50,195 Cost per Recipient - $3,414

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 895 DDSN Medicaid Services

Reimburse DDSN for Home and Community Based Long Term Care for the Mentally Retarded and Head and Spinal Cord injured populations. Both services are provided through waivers. Services include residential habilitation, prevocational habilitation, supported employment, day habilitation, personal care services, home and vehicle modifications. Behavior Health Services: SCDDSN facilitates and coordinates services that will ensure all Medicaid clients access to the full array of needed community assistance. This shall include access to services specifically for individuals with disabilities and dually diagnosed children and adults. Early Intervention: (EI) Services are medically necessary services provided for the purpose of facilitating correction or amelioration of developmental delay and/or disability. Conditions left untreated, would negatively impact the health and quality of life of the child. EI Services consist of the provision of Family Training and Service Coordination Services to children with developmental delay and/or disability, age 0-6 and their families.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $469,128,718 | $0 | $327,827,148 | Yes | $141,301,570 | 0.00 |

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Expected Results:**

Services utilized to provide support for community based living to those individuals with mental retardation, developmental disabilities, and/or head and spinal cord injuries and prevent institutionalization in either a Nursing facility or ICF/MR. BHS: Facilitation and coordination of services that will ensure all individuals access to the full array of needed community services in a systematic, efficient manner. Specifically, assessment, care planning, referral and linkage and monitoring and follow-up may be provided. Early Intervention: Will provide assurance of timely access to community services and programs that can best meet the individual needs of the child. Coordinating transition from one milestone service to another (e.g., from EI to public school, Head Start, Early Head Start and child care in the community), giving parents information on health care, assisting with keeping appointments and etc. Family Training, trains parents/caregivers in the use of developmentally appropriate activities to enhance their child's development and family support.

**Outcome Measures:**

BHS: The occurrence and severity of disabilities will be reduced where possible. Disabled clients will function at an optimal level in the least restrictive level of care. Early Intervention: Early detection of genetic disorders will enhance treatment modalities for increased quality of life for Medicaid recipients. Coordination of services and care with public and private providers.

Total Transactions 733,653 Cost per Transaction - $564.84 Total Recipients - 18,509 Cost per Recipient - $22.389

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 896 DHEC Medicaid Services

Early Intervention (EI) Services are medically necessary services provided for the purpose of facilitating correction or amelioration of developmental delay and/or disability. Conditions left untreated, would negatively impact the health and quality of life of the child. EI Services consist of the provision of Family Training and Service Coordination Services to children with developmental delay and/or disability,age 0-6 and their families. Nursing Services for Children under 21 involves the provision of specialized health care services to children needing primary health care services. Dental: DHEC's Children's Rehabilitative Services (CRS Ortho) Program provides orthodontic services for Medicaid beneficiaries that have severe birth defects which result in craniofacial anomalies such as Cleft Lip and/or Cleft Palate, Prognathism, Crouzon's Syndrome, Apert's Syndrome, Mid-face and Growth Related Skeletal Deficiencies.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $44,008,516 | $0 | $30,753,151 | Yes | $13,255,365 | 0.00 |

**Expected Results:**

EI: Will provide assurance of timely access to community services and programs that can best meet the individual needs of the child. Coordinating transition from one milestone service to another (e.g. from EI to public school. Head Start, Early Head Start and child care in the community). giving parents information on health care, assisting with keeping appointments and etc. Family Training, trains parents/caregivers in the use of developmentally appropriate activities to enhance their child's development and family support. Nursing Services, will identify, coordinate and treat medical condition to increase level of functioning. Dental Providing access to care for treatment of these severe birth defects through the CRS program will lead to improved quality and

# Agency Activity Inventory
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## Appropriation Period: FY 2004-05

longevity of life through the ability of the patient to eat, drink and communicate normally as well as present a normal appearance.

**Outcome Measures:**

EI: Increase access to care, provide early detection, increase beneficiary utilization of prevention services. Dental: Yearly increase in number of beneficiaries receiving orthodontic treatment through the CRS program resulting from improved access to care. Coordination of services and care with public and private providers. The ability of the Patient to eat, drink and communicate normally as well as present a normal appearance. Total Transactions - 814,219 Cost per Transaction - $45.80 Total Recipients - 166,010 Cost per Recipient - $225

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 897 MUSC Medicaid Services

Behavioral Health Services: Provides financial support for an array of outpatient community mental health treatment services to severely emotionally disturbed children and chronically mentally ill adults. Early Intervention: Developmental Evaluation Center (DEC), Sickle Cell Case Management and Genetics Education services are a part of community service provision at MUSC. DEC services are comprehensive assessments performed for the purpose of identifying genetic disorders.Sickle Cell Case Management Services include counseling and case management services to patients with Sickle Cell Disease. Genetics Education Services are directed at children who have disabilities and/or developmental delays for the purpose of identifying children with or at risk of genetic disorders. Dental: MUSC operates a Maxillofacial Prosthodontic Clinic that serves the needs of patients with severe Oral and Maxillofacial disfigurement as a result of cancer or trauma (gunshot wounds, fire, accidents, etc.).

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $31,625,541 | $0 | $22,099,928 | Yes | $9,525,613 | 0.00 |

**Expected Results:**

BHS:The development of an individualized plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance to enhance individual living skills and to help prevent children, adolescents and their families from being institutionalized or hospitalized. Services emphasize the acquisition, development and expansion of rehabilitative skills needed to move forward in recovery, resulting in an improved quality of life for clients and their families. EI:These array of services will reduce costly hospitalization and provide access to community based services. To improve and restore functional abilities. Early detection of disease and treatment. Services provided for the purpose of facilitating correction or amelioration of developmental delay and/or disability. Conditions left untreated, would negatively impact the health and quality of life of the child.Dental: Medicaid beneficiaries that have suffered from cancer or trauma to the maxillofacial area are provided access to treatment that can repair and restore normal function.

**Outcome Measures:**

BHS:Improved functioning and security for seriously emotionally disturbed children and for mentally ill adults. In addition to improving quality of life, this should lead to a reduction in the costs associated with the treatment of these conditions by increasing community tenure. The occurrence and severity of disabilities will be reduced

# Agency Activity Inventory
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where possible. Clients will function at an optimal level in the least restrictive level of care. Outcomes include a reduction in hospitalizations and emergency room visits for this population. Another measure is the extent to which coordination of care exists between public and private providers. EI:Recipients will have access to a medical home and more likelihood to obtain medical care. Early detection of genetic disorders will enhance treatment modalities for increased quality of life for Medicaid recipients. Coordination of services and care with public and private providers. Decrease in hospitalizations and emergency room visits. Dental:Comparison reports on the number of unduplicated recipients, transactions and expenditures for the Prosthodontic program for previous fiscal years. Beneficiaries will regain the ability to eat, hear, breathe, communicate and return to as normal a life as possible. Total Transactions - 42,677 Cost per Transaction - $982.72 Total Recipients - 5,051 Cost per Recipient - $8,303

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 898 USC Medicaid Services

Early Intervention: Developmental Evaluation Center (DEC), Sickle Cell Case Management and Genetics Education services are a part of community service provision at USC. DEC services are comprehensive assessments performed for the purpose of identifying genetic disorders.Sickle Cell Case Management Services include counseling and case management services to patients with Sickle Cell Disease. Genetics Education Services are directed at children who have disabilities and/or developmental delays for the purpose of identifying children with or at risk of genetic disorders. Dental: USC operates a Maxillofacial Prosthodontic Clinic that serves the needs of patients with severe Oral and Maxillofacial disfigurement as a result of cancer or trauma (gunshot wounds, fire, accidents, etc.).The clinic rebuilds and restores function to the affected areas to provide the necessary tools for the patient's
survival.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $6,377,842 | $0 | $4,456,836 | Yes | $1,921,006 | 0.00 |

**Expected Results:**

EI:These array of services will reduce costly hospitalization and provide access to community based services. To improve and restore functional abilities. Early detection of disease and treatment. Services provided for the purpose of facilitating correction or amelioration of developmental delay and/or disability. Conditions left untreated, would negatively impact the health and quality of life of the child. Dental: Medicaid beneficiaries that have suffered from cancer or trauma to the maxillofacial area are provided access to treatment that can repair and restore normal function.

**Outcome Measures:**

EI:Recipients will have access to a medical home and more likelihood to obtain medical care. Early detection of genetic disorders will enhance treatment modalities for increased quality of life for Medicaid recipients. Coordination of services and care with public and private providers. Decrease in hospitalizations and emergency room visits. Dental:Comparison reports on the number of unduplicated recipients, transactions and expenditures for the Prosthodontic program for previous fiscal years. Beneficiaries will regain the ability to eat, hear, breathe, communicate and return to as normal a life as possible. Total Transactions - 4,904 Cost per Transaction - $1,160.40 Total Recipients - 2,325 Cost per Recipient - $2,448

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 899 DAODAS Medicaid Services

Provides financial support for alcohol and other drug abuse rehabilitative services to enable DAODAS to ensure the provision of quality services to prevent or reduce the negative consequences of substance use and addictions.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $13,454,399 | $0 | $9,401,934 | Yes | $4,052,465 | 0.00 |

**Expected Results:**

DAODAS partners with public, private and social sector organizations to provide quality prevention, intervention and treatment services for the Medicaid clients. The ultimate goal of the program is recovery and long-term abstinence from drugs and alcohol.

**Outcome Measures:**

Clients are treated so they may re-enter society and lead responsible, successful drug and alcohol free lives by using the tools of recovery they receive during treatment. Outcomes include reducing involvement with the criminal justice system, reducing client emergency room visitation. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 146,347 Cost per Transaction - $94.84 Total Recipients - 8,929 Cost per Recipient - $1,554

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 900 Continuum of Care

Case Management Services and Wraparound Services are available to Medicaid eligible recipients. These services provide for coordination of care so that all CCEDC clients have planned access to the full array of medically necessary services specifically for emotionally disturbed children.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $11,737,068 | $0 | $8,201,863 | Yes | $3,535,205 | 0.00 |

**Expected Results:**

Targeted Case Management services are provided to these children to ensure that their medical, developmental and safety needs are met through coordinated, comprehensive and integrated service delivery. Each client's case manager works to ensure that all needed services are delivered. Wraparound Services are provided to children under 21 years of age who have special emotional/behavioral needs and their families. Specifically, assessment,

# Agency Activity Inventory
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## Appropriation Period: FY 2004-05

care planning, referral and linkage and monitoring and follow-up may be provided. These services are provided in order to stabilize or strengthen the child's current placement or prevent out-of-home care. Wrap-Around Services are treatment oriented and goal directed. Without the provision of Wrap-Around Services, such as counseling, therapy, behavioral intervention, or independent living skills, the child may be in jeopardy of placement disruption. Public and private providers provide this service.

**Outcome Measures:**

Youth will function better at home, at school and in the community. Outcomes include prevention of more costly and restrictive treatment options through adherence to a philosophy of community based, most normative and least restrictive services delivery and the facilitation of permanency through reunification or permanent guardianship. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 34,221 Cost per Transaction - $260.02 Total Recipients - 521 Cost per Recipient - $17,079

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 901 Hospital Services

Provides inpatient hospital care to individuals who require specialized institutional and professional services on a continuous basis, generally a 24 hour period. Provides outpatient hospital services that are diagnostic, therapeutic, rehabilitative or palliative items or services generally not to exceed a 24 hour period. This is a mandatory service. Authority for all HHS activities: Federal Law 42CFR Parts 430-498 SC Code 44-6-5 thru 44-6-910

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $623,213,727 | $158,989,489 | $436,927,157 | Yes | $27,297,081 | 0.00 |

**Expected Results:**

Provide quality care for individuals requiring acute care or outpatient services based on the severity of the illness.

**Outcome Measures:**

Total Transactions - 1,489,703 Cost per Transaction - $408.62 Total Recipients - 397,239 Cost per Recipient Inpatient Hospital - $4,805 Cost per Recipient Outpatient Hospital - $260 SE Average Cost per Recipient Inpatient Hospital - $4,449 SE Average Cost per Recipient Outpatient Hospital - $541 Mandatory Eligibles 85.28% Optional Eligibles 14.72%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 902 Hospital Services Administration

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Sets policies, procedures & guidelines for delivery of services in acute care hospitals. Conducts prior authorization/prepayment medical review for a variety of services. Supports provider base through claims resolution & processing, policy development, interpretation &clarification.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $1,063,544 | $531,772 | $531,772 | Yes | $0 | 15.20 |

**Expected Results:**

To develop fair and equitable Medicaid reimbursement for inpatient and outpatient services for hospitals contracting with the South Carolina Medicaid Program based upon a federally approved rate setting methodology. · Maintenance of acute care hospital provider base · Increase in enrollment · Quality health care for Medicaid beneficiaries

**Outcome Measures:**

Reviewed 105 FY 2001 hospital cost reports to determine Medicaid inpatient and outpatient cost to charge ratios for use in projecting interim Medicaid inpatient and outpatient cost settlements for DSH hospitals for the period October 1, 2003 through September 30, 2004 (and applicable match requirements for the non state owned public DSH hospitals). · 9,100 pieces of correspondence · 16,740 provider calls · 14,325 claims status checks · 1,350 beneficiary calls

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 903 Nursing Home Services

Provides nursing, therapy, and personal care services to individuals who do not require acute hospital care, but whose mental or physical condition requires services that are above the level of room and board and can be made available through licensed, certified, and contracted institutional facilities. This service is mandatory for skilled nursing care only. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $368,448,679 | $105,554,683 | $257,471,937 | Yes | $5,422,059 | 0.00 |

**Expected Results:**

To provide quality appropriate level of care 24 hours a day to residents in nursing homes.

**Outcome Measures:**

DHHS Contracts with DHEC to conduct annual surveys of nursing homes. A report of specific deficiencies is generated and submitted to DHHS. Report includes facilities surveyed, F tags cited, including scope and severity measures. Facilities work with State Quality Improvement Organizations and participate in Best Practice/culture change related activities in an effort to prevent substandard quality of care and immediate jeopardy surveys. Total Patient Days -4,231,218 Cost per Transaction - $2,818.62 Total Recipients - 16,626 Cost per Recipient - $25,326 SE Average Cost per Recipient - $20,438 Mandatory Eligibles 9.34% Optional

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Eligibles 90.66%

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 904 Nursing Home Services Administration

Supports nursing home providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation & clarification, and rate setting. Administers nursing home contracts.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $7,452,836 | $1,710,569 | $3,742,267 | Yes | $2,000,000 | 15.50 |

**Expected Results:**

To develop fair and equitable Medicaid reimbursement rates for nursing facilities participating in the South Carolina Medicaid Program based upon a federally approved rate setting methodology.

**Outcome Measures:**

Reviewed 146 FY 2002 nursing facility cost reports and 26 FY 2002 home office cost reports to determine Medicaid nursing facility rates effective October 1, 2003. Established 59 account receivables and 3 account payables relating to the Office of the State Auditor's audit activities of nursing facilities. There will be a decrease in the number of immediate jeopardy and substandard quality surveys. This will be accomplished through monitoring of the nursing home sanctioning process, nursing homes participation with the State Quality Improvement Organizations, and Best Practices/culture change related activities.

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 905 Pharmaceutical Services

Provides needed pharmaceuticals for the purpose of saving lives in emergency situations or during short-term illness, to sustain life in chronic or long term illness, or to limit the need for hospitalization. Covered pharmacy services include the provision of most rebated prescription and over-the-counter generic pharmaceuticals. Pharmacy services for institutional care and children are required, all other pharmacy services are optional. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $711,162,861 | $148,941,771 | $477,597,636 | Yes | $84,623,454 | 0.00 |

**Expected Results:**

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Drug coverage for both Medicaid and SILVERxCARD beneficiaries (except for a difference in the co-payment requirements and an annual calendar year deductible requirement, SILVERxCARD beneficiaries are subject to the same Medicaid Pharmacy Services' policies as other adult Medicaid beneficiaries). Prior authorization is necessary for certain products, according to certain established criteria.

**Outcome Measures:**

Greater than 99% of all pharmacy claims are adjudicated and filed for reimbursement electronically via our point of sale system. Payment to providers is made weekly. SILVERxCARD Total Transactions 1,128,514 Cost per Transaction - $38.68 Total Recipients 30,368 Cost per Recipient - $1,437 TOTAL for all Pharmacy Transactions 10,970,996(prescriptions) Cost per Transaction - $57.36 Total Recipients 596,842(unduplicated) Cost per Recipient - $997 SE Average Cost per Recipient - $1,095 Mandatory Eligibles 58.73% Optional Eligibles 41.27%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 906 Pharmaceutical Services Administration

Provides support to Pharmacy providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification. Administers the Pharmacy Benefits Manager contract. Supports the Pharmacy and Therapeutics Committee.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $5,197,422 | $216,907 | $3,789,613 | Yes | $1,190,902 | 6.20 |

**Expected Results:**

Maintenance of Pharmacy professionals base. Increase in enrollment of pharmacies. Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 907 Physician Services

Reimburse physicians enrolled in the Medicaid program for services. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $251,164,646 | $66,715,980 | $176,546,553 | Yes | $7,902,113 | 0.00 |

**Expected Results:**

Medicaid eligible persons have access to physician services.

**Outcome Measures:**

Total transactions - 4,421,068 Cost per Transaction - $54.18 Total Recipients - 518,306 Cost per Recipient - $462 SE Average Cost per Recipient - $465 Mandatory Eligibles 89.33% Optional Eligibles 10.67%

---

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 908 Physician Services Administration

Provides support to primary care physicians & over 40 different practice specialty physicians and associated health groups participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification, rate setting, and assisting with budget management. This department also manages contracts and programs designed to provide/encourage immunizations, rural health care, and health screenings for children.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $1,714,264 | $857,132 | $857,132 | Yes | $0 | 24.50 |

**Expected Results:**

Maintenance of Physicians and other professionals base. Increase in enrollment of physicians. Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Resolution of over 90,440 paper claims. 22,416 pieces of written correspondence. 76,140 provider/beneficiary telephone inquiries.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 909 Dental Services

Children under the age of 21 are provided a range of preventive and restorative dental services, including a complete dental examination every 6 months. Education for establishing and maintaining good oral health as the preventive aspect of dental services. Adults, age 21 and over, are provided emergency and catastrophic health related dental services. Services for children are mandatory, for adults, only medical and surgical services are mandatory. Authority for this activity is contained

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $106,181,814 | $26,451,416 | $74,795,935 | Yes | $4,934,463 | 0.00 |

**Expected Results:**

Increase in access to educational measures for the prevention of dental disease, restoration of teeth and maintenance of dental health for Medicaid beneficiaries.

**Outcome Measures:**

Increase in number of beneficiaries utilizing preventive services and cost containment of dental restorative procedures. Total Transactions - 1,994,068 Cost per Transaction - $44.72 Total Recipients - 253,117 Cost per Recipient - $352 SE Average Cost per Recipient - $282 Mandatory Eligibles 83.33% Optional Eligibles 16.67%

---

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 910 Dental Services Administration

Provides support to dentists participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $349,850 | $174,925 | $174,925 | Yes | $0 | 5.00 |

**Expected Results:**

Maintenance of Dentists base. Increase in enrollment of dentists. Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 911 Community Long Term Care

CLTC consists of central office staff who provide general oversight of the CLTC programs and regional staff in 13 offices around the state who provide day to day operational activities. Central office staff members provide support to CLTC and waiver services providers participating in the Medicaid program through claims resolution & processing, policy development,

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

interpretation &clarification. Regional staff housed in the 13 area offices provide case management to waiver recipients, conduct preadmission screening and level of care determinations for nursing home and waiver applicants. They also engage in day to day activities for the oversight of PASARR, TEFRA, children's personal care services and other long term care related activities.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $99,650,026 | $27,638,910 | $69,912,710 | Yes | $2,098,406 | 0.00 |

**Expected Results:**

1) Central office will enroll qualified providers in a timely manner.· 2) Central office will review providers in a timely manner to ensure adherence and compliance with all contractual requirements. 3) Central office will conduct area office staff reviews to assure compliance with waiver requirements. 4) Area office staff members will conduct level of care determinations for nursing home applicants within two weeks of referral 5) Case managers will provide case management for 100% of waiver recipients. 6) CLTC will fill all available waiver slots in a timely manner. 7) CLTC will maximize federal financial participation for all regional staff in order to control program expenditures.

**Outcome Measures:**

1) All providers will be enrolled within 45 days of submitting completed applications. 2) Annual reviews will be conducted on all providers. 3) Administrative reviews will be conducted for each regional office on an annual basis. 4) Computer reviews will determine the percentage of nursing home assessments completed within two weeks. 5) Care Call reports will determine the percentage of waiver recipients receiving case management services. 6) Weekly reports indicate the number of clients in filled slots for each waiver. 7) Fiscal reports will indicate whether or not all case management FTEs and their activities are reimbursed at the FMAP rate (approximately 70% federal share); fiscal reports will indicate whether or not all registered nurse FTEs and their activities are reimbursed at the skilled medical professional rate (75% federal share).

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 912 Community Long Term Care Administration

Provides support to CLTC and waiver services providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $18,295,924 | $8,267,770 | $9,828,154 | Yes | $200,000 | 222.00 |

**Expected Results:**

· Maintenance of provider base · Increase in enrollment of providers · Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 913 Home Health Services

Service provided to eligible Medicaid recipients, affected by illness or disability at his/her place of residence, based on physician's orders and/or a specific plan of care. These services provide part-time or intermittent nursing, aide services and therapies (i.e., physical, speech, or occupational) and supplies, which are ordered by the physician and used during the course of a visit. These services are limited to seventy-five (75) visits per fiscal year. This is a mandatory service. 42CFR Part 484, State Law Title 44, 44-6-5 - 44-6-910

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $14,600,289 | $2,575,647 | $10,694,335 | Yes | $1,330,307 | 0.00 |

**Expected Results:**

To improve the patient's level of functioning, to relieve pain, and prevent regression of the patient's stable condition. The plan of care should restrict such care to the minimum number of visits necessary to meet these objectives.

**Outcome Measures:**

Total Transactions - 128,495 Cost per Transaction - $88.90 Total Recipients - 7,328 Cost per Recipient - $1,559 SE Average Cost per Recipient - $3,137 Mandatory Eligibles 79.51% Optional Eligibles 20.49%

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 914 Home Health Services Administration

Provides support to Home Health Services providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $69,970 | $34,985 | $34,985 | Yes | $0 | 1.00 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment of providers. Quality health care for Medicaid beneficiaries.

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 915 EPSDT Screening

The Early and Periodic Screening, Diagnostic, and Treatment service (EPSDT) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. It assures the availability and accessibility of required health care resources and helps Medicaid recipients and their parents or guardians effectively use these resources. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $12,017,002 | $3,332,663 | $8,397,481 | Yes | $286,858 | 0.00 |

**Expected Results:**

Increased services to children. Decrease in overall costs due to early screening and identification of health issues

**Outcome Measures:**

Total Transactions - 209,989 Cost per Transaction - $55.20 Total Recipients - 116,225 Cost per Recipient - $100 SE Average Cost per Recipient - $105 Mandatory Eligibles 95.44% Optional Eligibles 4.56%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 916 EPSDT Screening Administration

Provide support and assistance to physicians who participate in the Early and Periodic Screening, Diagnostic, and Treatment service (EPSDT).

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $3,440,767 | $886,773 | $2,413,994 | Yes | $140,000 | 0.40 |

**Expected Results:**

Maintenance of provider base. Increase in provider enrollment. Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 917 Medical Professional Svcs.

Reimburse optometrists, opticians, podiatrists, audiologists, chiropractors, speech therapists, physical and occupational therapists participating in the Medicaid program for services. Only services of nurse practitioners and midwives are mandatory, all other practitioner services in this category are optional. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $17,206,245 | $4,693,710 | $12,023,724 | Yes | $488,811 | 0.00 |

**Expected Results:**

Medicaid eligible persons have access to services.

**Outcome Measures:**

Total Transactions - 636,661 Cost per Transaction - $26.07 Total Recipients - 153,760 Cost per Recipient - $108 SE Average Cost per Recipient - $317 Mandatory Eligibles 86.15% Optional Eligibles 13.85%

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 918 Medical Professional Svcs. Administration

Supports optometrists, opticians, podiatrists, audiologists, chiropractors, speech therapists, physical and occupational therapists participating in the Medicaid program through claims resolution & processing, policy development, interpretation & clarification.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $188,918 | $94,459 | $94,459 | Yes | $0 | 2.70 |

**Expected Results:**

· Maintenance of provider base · Increase in provider enrollment · Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

· Resolution of over 4000 paper claims · 1800 pieces of written correspondence · 9000 provider/beneficiary telephone inquiries

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 919 Transportation Services

Reimburse transportation providers participating in the Medicaid program for services. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $45,308,380 | $13,280,829 | $31,661,496 | Yes | $366,055 | 0.00 |

**Expected Results:**

Medicaid eligible persons have access to services.

**Outcome Measures:**

Medicaid Transportation conducts a comparison of year-end, program wide results on a number of key indicators: expenditures, number of trips, unduplicated beneficiaries served, documentation deficiencies and quality assurance deficiencies. Service criteria also include the percentage of pick-ups and deliveries completed on time, safety, reliability, waiting times and access to bi-lingual services. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 478,141 Cost per Transaction - $91.41 Total Recipients - 51,030 Cost per Recipient - $856 Mandatory Eligibles 30.11% Optional Eligibles 69.89%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 920 Transportation Services Administration

Medicaid Transportation Program provides support for emergency and non-emergency transportation to and from medical services to eligible beneficiaries. The transportation program assures the delivery of and reimbursement for transportation services including disabled persons by Ambulance, Individual, Contractual and Out-of-State arrangements during regular, after hour and for emergency services.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $524,774 | $262,387 | $262,387 | Yes | $0 | 7.50 |

**Expected Results:**

All transportation except emergencies must be prior authorized, if it is provided by an enrolled provider, and must be the least expensive and most appropriate method of transportation available. DHHS monitors the transportation network to maximize the beneficiaries access to transportation services and minimize the beneficiaries waiting

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

and riding times.

**Outcome Measures:**

Medicaid Transportation conducts a comparison of year-end, program wide results based on expenditures, number of trips, unduplicated beneficiaries served, documentation deficiencies and quality assurance deficiencies. Service criteria also include the percentage of pick-ups and deliveries completed on time, safety, reliability, waiting times and access to bi-lingual services. Another measure is the extent to which coordination of care exists between public and private providers.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 921 Lab and X-Ray Services

Reimburse providers for lab and x-ray services. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $28,096,640 | $8,007,071 | $19,633,932 | Yes | $455,637 | 0.00 |

**Expected Results:**

Medicaid eligibles have access to services

**Outcome Measures:**

Total Transactions -1,534,996 Cost per Transaction - $17.66 Total Recipients - 239,743 Cost per Recipient - $113 SE Average Cost per Recipient - $104 Mandatory Eligibles 92.04% Optional Eligibles 7.96%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 922 Lab and X-Ray Services Administration

Provides support to lab and x-ray providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $101,456 | $50,728 | $50,728 | Yes | $0 | 1.45 |

**Expected Results:**

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Maintenance of provider base. Increase in enrollment. Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 923 Family Planning Services

Under the Family Planning Waiver, the state will reimburse providers for Family Planning services for Medicaid beneficiaries. This includes two eligible groups: (1)postpartum women who transition to the waiver from the Optional Coverage for Women and Infants (OCWI) may receive 24 months of family planning eligibility. This 24 month period includes the 2 months or Medicaid eligibility after delivery, and, (2) expansion population that consists of women at or below 185% of poverty may receive FP services for 24 months, regardless of whether there was a Medicaid reimbursed pregnancy. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $26,853,929 | $2,472,376 | $24,251,926 | Yes | $129,627 | 0.00 |

**Expected Results:**

Medicaid eligible persons have access to services that will reduce the number of unintended and unwanted pregnancies resulting in births reimbursed under the SC Medicaid program. The goals are as follows: 1. Assure that all women who want and need publicly supported family planning services receive such services. 2. Increase the age at first birth among all women eligible for family planning services under the waiver. 3. Reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid. 4. Reduce over Medicaid expenditures for unintended and unwanted pregnancies by investing in family planning preventative services for women at or below 185% of poverty. 5. Promote partnership with community health centers for primary medical care homes for waiver participants.

**Outcome Measures:**

During last year (February 1, 2003 through January 31, 2004), there were 104,864 women enrolled in the program. Of these, 55,376 unduplicated recipients received a family planning service. In addition, an interim evaluation was done by the Center for Health Services & Policy Research, Arnold School of Public Health, USC and submitted in May, 2004. They reported that since 1995 through 2002, the SC Medicaid program has saved an estimated $62 million dollars by averting births which would have been otherwise covered by Medicaid. Total Transactions - 561,367 Cost per Transaction - $34.77 Total Recipients - 112,684 Cost per Recipient - $173 SE Average Cost per Recipient - $383 Mandatory Eligibles 55.82% Optional Eligibles 44.18%

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**Agency:** J02 - Health & Human Services Finance

**Functional Group:** Health

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Commission

### 924 Family Planning Services Administration

Provides support to family planning providers participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

| FY 2004-05 | | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $479,994 | $239,997 | $239,997 | Yes | $0 | 6.86 |

**Expected Results:**

Maintenance of provider base. Increase in enrollment. Quality health care for Medicaid beneficiaries. Decreased number of unplanned/mistimed pregnancies. Increased use of appropriate family planning.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 925 Medicare Premium Payments

Medicaid pays the Medicare premiums for recipients identified by Medicare. Medicare sends a tape with the recipients information, which is then interfaced through Automated Claims Processing. Medicaid also pays premiums, deductibles, and co-insurance for recipients eligible for enrollment in employer-based group health plans. This is a mandatory service. Authority for this activity is contained in 42CFR Parts 430-498, State Law Title 44, 44-6-5 - 44-6-910.

| FY 2004-05 | | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $82,008,684 | $25,450,912 | $52,195,956 | Yes | $4,361,816 | 0.00 |

**Expected Results:**

Reduction in expenditures due to payment of premiums rather than medical claims.

**Outcome Measures:**

Total Transactions - 1,481,454 Cost per Transaction - $66.41 Matched, $61.52 State only Total Recipients - 140,514 Cost per Recipient - $718 Matched, $496 State only Mandatory Eligibles 50.62% Optional Eligibles 49.68%

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**Agency:** J02 - Health & Human Services Finance

**Functional Group:** Health

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Commission

### 926 Hospice Care

Service provided to eligible Medicaid recipients who have been certified as being terminally ill. An individual is considered to be terminally if the individual has a medical prognosis that his/her life expectancy is six (6) months or less if the disease runs its normal course. Services provided will include nursing, medical social services, physician, counseling, medical appliances including drugs and biologicals, aide, homemakers and therapy services. Continuous home care is provided only during a period of crisis. This is an optional service. 42CFR Part 418, State Law Title 44, 44-6-5 - 44-6-910

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $4,981,952 | $1,349,207 | $3,510,179 | Yes | $122,566 | 0.00 |

**Expected Results:**

To provide complete and comprehensive medical services to the Medicaid recipient and his/her family dealing with "end of life" situations and receive needed services at home.

**Outcome Measures:**

1)There will be a reduction in hospital visits and nursing home admissions for these recipients compared to admissions prior to receiving Hospice. 2)Reimbursement for services will be adequate for the recipient to remain in the home. 3)All contracted providers will maintain compliance with the Medicaid program guidelines, educated in correct billing practices. Total Transactions - 3,112 Cost per Transaction - $1,517.93 Total Recipients - 601 Cost per Recipient - $7,860 Mandatory Eligibles 72.83% Optional Eligibles 27.17%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 927 Hospice Care Administration

Program staff provide oversight to the Hospice program claims resolution & processing, policy development, interpretation &clarification. Administrative staff enters hospice election, discharge, and revocation data into the Medicaid Management Information System (MMIS) Recipient Special Program (RSP) in order for providers to receive timely payment. Staff provide programmatic technical assistance for newly contracted providers and annually determine reimbursement rates by MSA adjustments of CMS mandated rates. Staff collect annual Medicaid Client Data Summaries from each provider to analyze and compile for a statewide utilization report.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $69,970 | $34,985 | $34,985 | Yes | $0 | 1.00 |

**Expected Results:**

The Medicaid Hospice program, through analytical review of Federal Regulations, will support Medicaid hospice and end of life providers. Hospice provider claims are paid appropriately and correctly since the hospice. Hospice providers are reimbursed competitive, MSA adjust rates effective on the first day of the Federal FY. Completion of data summary reflects appropriate statewide utilization of services.

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

**Outcome Measures:**

Fifty-six state certified providers will have necessary information and guidance to comply with Medicaid requirements of participation. No violations will be identified through annual certifications by DHEC. Hospice client data is received through the mail, reviewed for compliance and entered in the MMIS/RSP system within 24 hours of mail date stamp. Hospice providers will comply with all program procedures as a result of receiving a technical assistance consultation within 3 moths of contracting with DHHS. CMS issued reimbursement rates are adjusted according to MSA ratio and entered into the MMIS system by 9/30 each year for 10/1 dates of service. Medicaid data summary is collected by 2/28 each year, summarized and distributed for public review and comment.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 928 Residential Care Facility

Optional State Supplementation is designed to provide a monthly payment on behalf of eligible aged, blind, or disabled persons who need assistance paying licensed/enrolled Community Residential Care Facility (CRCF) where they live. A CRCF must be enrolled with DHHS for recipients to participate in OSS. This is an optional service. Title XVI, Section 1616(a) of the Social Security Act, 42CFR Part 435.230, SC State Regulations, Chapter 114, Article 19

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $18,079,046 | $17,552,962 | $0 | No | $526,084 | 0.00 |

**Expected Results:**

A monthly payment is made to the CRCF for than actual number of days that the resident received room and board from the facility as indicated on the monthly billing document submitted by the facility.

**Outcome Measures:**

Total Transactions - 52,784 Cost per Transaction - $283.92 Total Recipients - 5,494 Cost per Recipient - $2,728 Mandatory Eligibles 65.26% Optional Eligibles 34.74%

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 929 Residential Care Facility Administration

Provides support to Residential Care Facilities participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification.

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $69,970 | $34,985 | $34,985 | Yes | $0 | 1.00 |

**Expected Results:**

To determine the aggregate annual cost increase incurred by providers rendering services under the South Carolina Optional State Supplement
Program.

· Maintenance of provider base · Increase in enrollment · Quality health care for Medicaid beneficiaries

**Outcome Measures:**

Reviewed 290 FY 2003 residential care facility cost reports to determine the aggregate annual cost increase incurred by the providers participating in the Optional State Supplement Program. 1)There will be an increase in the number of CRCFs that successfully enroll with DHHS in order for their residents to participate in the OSS program compared to 2003. 2) There will be a progressive decrease in the time of enrollment of a facility to the date of instruction on procedures by DHHS staff. 3) More than 90% of the billing documents will be submitted error free. 4) There will be an increase in the number of monthly payments made on time with no errors.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 930 Integrated Personal Care

Assistance with activities of daily living is provided eligible Medicaid recipients who reside in participating assisted living facilities with training and oversight of unlicensed staff provided by licensed nurse's. This is an optional service. 2004 Act No. 248, Part IB, Proviso 8.13 and 42CFR Part 430 to end.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $976,434 | $279,702 | $691,192 | Yes | $5,540 | 0.00 |

**Expected Results:**

To improve the quality of care and quality of life for residents of assisted living facilities and to prevent or delay institutionalization of the resident's)

**Outcome Measures:**

Total Transactions - 3,111 Cost per Transaction - $380.07 Total Recipients - 496 Cost per Recipient - $2,384 Mandatory Eligibles 65.38% Optional Eligibles 34.62%

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**Agency:** J02 - Health & Human Services Finance

**Functional Group:** Health

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Commission

### 931 School for the Deaf and Blind

SBS:The services are delivered based on medical necessity and individual treatment plans. These services include physical therapy, audiology, occupational therapy, speech therapy, nursing services and psychological services provided school districts for the purpose of evaluating and treating disorders in children with the optimal goal of improving function. BHS: Financial support is provided for the provision of Wraparound services provided to deaf and blind children who are emotionally/behaviorally disturbed.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $2,327,945 | $0 | $1,626,768 | Yes | $701,177 | 0.00 |

**Expected Results:**

SBS: Identifying, coordinating and treating of medical conditions to increase level of functioning.EI: Early Intervention: Will provide assurance of timely access to community services and programs that can best meet the individual needs. Family Training, trains parents/caregivers in the use of developmentally appropriate activities to enhance their child's development and family supports assure that each person receives needed services in a supportive, effective, efficient, and cost effective manner. BHS: Wraparound Services are provided to children under 21 years of age who have special emotional/behavioral needs and their families. Specifically assessment, care planning, referral and linkage and monitoring and follow-up may be provided. These services are provided in order to stabilize or strengthen the child's current placement or prevent out of home care. Wraparound services are treatment oriented and goal directed. Without Wraparound Services, such as counseling, therapy, behavioral intervention, or independent living skills, the child may be in risk of placement disruption.

**Outcome Measures:**

SBS: Increase access to care, provide early detection, increase beneficiary utilization of prevention services and early detection. Another measure is the extent to which coordination of care exists between public and private providers. Early Intervention: Early detection of genetic disorders will enhance treatment modalities for increased quality of life for Medicaid recipients. Coordination of services and care with public and private providers. Outcomes are developed in conjunction with the families based on mutual identifies needs. SBS. Youth will function better at home, at school and in the community,. Outcomes include prevention of more costly and restrictive treatment options through adherence to a philosophy of community based, most normative and least restrictive services delivery and the facilitation of permanency through reunification or permanent guardianship. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 42,034 Cost per Transaction - $61.48 Total Recipients - 621 Cost per Recipient - $4,161

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 932 DSS Medicaid Services

Behavioral Health Services: Financial support is provided for Case Management Services for adults in Adult Protective Services ages 18 and older and for children in foster care ages 0-21. Case Management Services involve the coordination of

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appropriate services in to ensure the safety and well-being of children and adults who cannot protect themselves. Specialized Foster Home Services (SHFS) and Medical Therapeutic Foster Care home services are residential services provided in a specially recruited, professionally supervised therapeutic foster homes. to provide mental health and rehabilitative treatment programs for Medicaid eligible children. Early Intervention: The Medically Fragile Foster Parent Training Service assist foster parents of medically fragile children to manage their health care needs.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $59,301,139 | $0 | $41,439,636 | Yes | $17,861,503 | 0.00 |

**Expected Results:**

BHS: Case Management services are provided to these children and vulnerable adults to ensure that their medically based and safety needs are met through coordinated, comprehensive and integrated service delivery. Each client's case manager works to ensure that all needed services are delivered. Specialized Foster Home Services (SHFS) and Medical Therapeutic Foster Care home services to provide mental health and rehabilitative treatment programs for Medicaid eligible children in specially supervised homes. EI: Continuity of care, provides access to community based services and reduces costly hospitalizations. This service supports placement of children in foster care and leads to longevity of placement.

**Outcome Measures:**

BHS: Outcomes include prevention of more costly and restrictive treatment options through adherence to a philosophy of community based, most normative and least restrictive services delivery. Another measure is the extent to which coordination of care exists between public and private providers. EI: Quality of life, children remain in a natural environment and moves from foster care to adoption more readily. Coordination of services and care with public and private providers. Total Transactions - 114,149 Cost per Transaction - $440.87 Total Recipients - 12,258 Cost per Recipient - $4,105

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 933 DJJ Medicaid Services

Behavioral Health Services: Financial support is provided for the provision of mental health and rehabilitative services to clients of DJJ who are emotionally disturbed and who are residing in the community. All services are based on medical necessity and an individualized treatment plan. Support for mental health and rehabilitative residential services is also provided under some circumstances.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $26,817,141 | $0 | $18,739,818 | Yes | $8,077,323 | 0.00 |

**Expected Results:**

SCDJJ makes available to Medicaid eligible children under age 21 mental health and rehabilitative services based on an individualized treatment plan and documented medical necessity. Services will enhance community safety and well-being as re-offense rates drop and children are able to improve functioning at home, in school and in the community.

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**Outcome Measures:**

Due to treatment for serious emotional disturbance, a decrease is anticipated in involvement with the juvenile justice system. Community tenure for these clients is expected to increase as a result of treatment. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 49,247 Cost per Transaction - $415.24 Total Recipients - 7,958 Cost per Recipient - $2,570

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 934 Dept of Education Medicaid

Financial support is provided to Medicaid eligible under 21 to include emotionally disturbed children. The services are delivered based on medical necessity and individual treatment plans. These services include physical therapy, wrap-around services, therapeutic child treatment, clinical day programming, applied behavioral therapy services, audiology , Medicaid adolescent pregnancy prevention services, occupational therapy, speech therapy, nursing services and psychological services provided in local school districts for the purpose of evaluating and treating disorders in children with the optimal goal of improving function. Nursing Services for Children under 21 involves the provision of specialized health care services to children needing primary health care services.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $79,509,754 | $0 | $55,561,416 | Yes | $23,948,338 | 0.00 |

**Expected Results:**

BHS: Each school district determines which of these services will be offered to Medicaid eligible emotionally disturbed children. Services are provided to integrate therapeutic interventions with educational to reduce maladaptive behaviors and foster health family relationships. Certain services are designed to prevent child maltreatment and increase the families' enhanced ability to meet the therapeutic needs of the child. Other services prevent more costly and restrictive treatment options and assist children in functioning successfully within their home and school environments. School Based: Identifying, coordinating and treating of medical conditions to increase level of functioning.

**Outcome Measures:**

BHS: Anticipated outcomes include improved functioning and performance in school, at home and in the community. Other measures evaluate whether children that received these services are residing with a consistent, stable caregiver, whether children receiving these services remain in a regular day care or school program after discharge and whether there are fewer attendance problems, suspensions and other disciplinary actions. EI: Increase access to care, provide early detection, increase beneficiary utilization of prevention services and early detection. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 1,575,678 Cost per Transaction - $43.60 Total Recipients - 69,568 Cost per Recipient - $988

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 935 Commission for the Blind

Case management services are available to Medicaid eligible sensory impaired individuals, to include low vision services and low vision aids to Medicaid eligible children 5-10 years old.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $28,924 | $0 | $20,212 | Yes | $8,712 | 0.00 |

**Expected Results:**

To ensure that follow up monitoring will take place in schools and in homes to assure maximum use of devices/aids to maximum the use of any remaining sight.

**Outcome Measures:**

Enhanced treatment modalities for increase quality of life. Coordination of services and care with public and private providers. Total Transactions - 322 Cost per Transaction - $27.56 Total Recipients - 136 Cost per Recipient - $65

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 936 Emotionally Disturbed Children

Financial support is provided to ensure coordinated, comprehensive access to services for ISCEDC children.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $52,456,839 | $0 | $36,656,839 | Yes | $15,800,000 | 0.00 |

**Expected Results:**

Access to services is enhanced by arranging needed care and services, monitoring the cases on an on-going basis, providing crisis assessment and referral services and providing needed follow-up and communicating regularly with other involved agencies/providers. Specifically, assessment, care planning, referral and linkage and monitoring and follow-up are among the services that may be provided. These services are designed to address therapeutic placements of emotionally disturbed children in SC, the quality of treatment services, the avoidance of more costly and restrictive treatment options, adherence to a philosophy of community based, most normative and least restrictive services delivery and the facilitation of permanency through reunification or permanent guardianship are outcomes.

**Outcome Measures:**

Improved functioning and security for seriously emotionally disturbed children.. In addition to improving quality of life, this should lead to a reduction in the costs associated with the treatment of these conditions by

# Agency Activity Inventory
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increasing community tenure. The occurrence and severity of disabilities will be reduced where possible. Clients will function at an optimal level in the least restrictive level of care. Functioning will improve at school, at home and in the community. Another measure is the extent to which coordination of care exists between public and private providers. Total Transactions - 154,220 Cost per Transaction - $353.87 Total Recipients - 2,010 Cost per Recipient - $27,151

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 937 Disproportionate Share

The South Carolina Medicaid Disproportionate Share Program (DSH) provides qualifying DSH hospitals with funding that allows the hospitals to recover a portion or all of its uncompensated Medicaid and uninsured patient costs.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $397,400,371 | $14,000,000 | $278,220,000 | Yes | $105,180,371 | 0.00 |

**Expected Results:**

To establish fair DSH qualification criteria and equitable Medicaid DSH payments for DSH qualifying hospitals contracting with the South Carolina Medicaid Program based upon a federally approved DSH payment methodology.

**Outcome Measures:**

Based upon the Medicaid inpatient and outpatient cost to charge ratios determined from the analysis of the FY 2001 hospital cost reports, the analysis of FY 2001 DSH qualification survey information, and the analysis of the FY 2001 uninsured information from the qualifying DSH hospitals, calculated and made DSH payments to the 60 qualifying DSH hospitals (and calculated the applicable DSH match requirements for the non state owned public hospitals).

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 938 Other Entities Medicaid Ser

Payments made to private providers, with matching funds provided by other state agencies and public entities. Other payment adjustments that are not directly associated with a specific service line.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $89,039,761 | $7,292,776 | $62,220,985 | Yes | $19,526,000 | 0.00 |

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**Expected Results:**

Medicaid eligible persons have access to services.

**Outcome Measures:**

Total Transactions - 276,068 Cost per Transaction - $762.39 Total Recipients - 23,127 Cost per Transaction - $9,101

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 939 Palmetto Senior Care

Palmetto SeniorCare (PSC) is a Medicaid State Plan program of comprehensive care that allows the frail elderly to live in their communities. PSC serves individuals age 55 and older who meet nursing home level of care at Day Health Centers located in portions of Richland and Lexington Counties, and who can be safely cared for in the community. *PSC is part of the national Program of All-inclusive Care for the Elderly (PACE), a benefit under Medicare and an optional state benefit under Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. The program brings together all the medical, functional and social services needed for someone who otherwise might be in a nursing home.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $11,968,127 | $0 | $8,363,327 | Yes | $3,604,800 | 0.00 |

**Expected Results:**

Under the terms of the PACE program, PSC is required to be a cost-effective alternative choice to nursing home care, providing total care at less then the average cost compared to the nursing home rate. *A team of health professionals assesses the participant's needs, develops a comprehensive plan of care and provides for total care. Generally, services are provided in an adult day health center, but also may be given in the participant's home, a hospital, long-term care facility, or in a nursing home. There is no co-pay, deductible or limit on services as authorized by the Interdisciplinary Team. Enrollment is voluntary, and once enrolled, PACE becomes the sole source of all Medicare and Medicaid covered services, as well as any other items or medical, social or rehabilitation services the PACE interdisciplinary team determines an enrollee needs. If a participant requires placement in a nursing home, PACE is responsible and accountable for the care and services provided and regularly evaluates the participant's condition.

**Outcome Measures:**

PSC operates under a risk-based capitated reimbursement methodology and receives a fixed monthly payment from Medicare and Medicaid for each participating beneficiary, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a participant may need. Overall costs must remain less than the average cost compared to the nursing home rate. The Medicaid payment rate is calculated to ensure it is below the nursing home all-inclusive rate. Total Transactions - 3,516 Cost per Transaction - $2,445.55 Total Recipients - 367 Cost per Recipient - $23,429

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# Agency Activity Inventory
## by Agency
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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 940 MUSC Maxillofacial Services

Special line item which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissue of the oral and maxillofacial regions

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $250,000 | $250,000 | $0 | No | $0 | 0.00 |

**Expected Results:**

Eligible persons have access to these services

**Outcome Measures:**

Services are performed in accordance with established procedures

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 941 Other Agencies Administration

Provides support to Other Agencies participating in the Medicaid program through claims resolution & processing, policy development, interpretation &clarification. Administers State Agency Contracts.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $56,166,596 | $411,423 | $28,557,763 | Yes | $27,197,410 | 16.60 |

**Expected Results:**

· Maintenance of Other Agencies professionals base · Increase in enrollment of providers · Quality health care for Medicaid beneficiaries.

**Outcome Measures:**

Claims resolution, written correspondence, provider/beneficiary telephone inquiries

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

# Agency Activity Inventory
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### 942 Medicaid Eligibility

Medicaid Eligibility determination is the primary activity of the 46 county offices of DHHS and the Central Eligibility Processing Division. All applicants for the SC Medicaid program must complete and submit a Medicaid application by mail or in person to an office of DHHS. The DHHS office staff approves or denies applications based on a combination of state and federal income and resource requirement and guidelines. Once approved, applicants are eligible to receive covered medical services, including hospital and doctor visits and prescriptions for one year from an enrolled Medicaid provider.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $30,753,653 | $5,358,476 | $15,086,196 | Yes | $10,308,981 | 516.00 |

**Expected Results:**

Medicaid eligibility is expected to be determined in an accurate and timely manner. Eligibility staff in the 46 county offices and the Central Processing Division are expected to provide Medicaid eligibility information and Medicaid applications to the general public; make eligibility initial determinations and redeterminations within 45 days of receipt of a signed application or renewal form (up to 90 days for disability determinations); and accurately and efficiently approve or deny eligibility.

**Outcome Measures:**

Outcome is measured by timely and accurate determination of Medicaid eligibility. The timeliness standard for determining eligibility is 45 days. Key indicators are a 97% accuracy rate for determining eligibility; determinations made within 45 days or 90 days for disability cases; and timely annual redetermination of eligibility so that beneficiaries who requalify remain eligible and continue to receive services and those who no longer qualify for Medicaid are promptly removed from the program.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 943 Medicaid Eligibility Support

The Medicaid Eligibility Determination System (MEDS) is used to determine and track Medicaid eligibility. MEDS assists in determining eligibility and in the tracking of applications, reviews, notices and other processes related to Medicaid eligibility. MEDS (Medicaid Eligibility Determination System ) User Services provides Help Desk support for MEDS, defines system enhancements, and resolves user problems. The MEDS Department of Interfaces is responsible for MEDS interfaces including problem resolution, system enhancements, and responding to SSI and Buy-In beneficiaries regarding eligibility issues. Beneficiary Services: 1) SCDHHS provides a toll-free number for beneficiaries to call when they have questions concerning their Medicaid enrollment, enrollment into a managed care health plan, or the services offered by Medicaid. 2) SCDHHS offers choices to Medicaid recipients in the way they receive their health care services, which includes Health Maintenance Organization, Physician Enhanced Program, and Primary Care Case Management program. Design and conduct regional, county specific and new worker Basic Job Training on policy, procedures, and the Medicaid Eligibility System (MEDS). Develop and revise statewide policies and procedures, as appropriate, to ensure compliance with state and federal requirements. Develop statewide policies to add new groups of recipients. Maintain policy manual; develop policy transmittals. Maintain forms and brochures. Maintain training modules for each program. Respond to beneficiary Legislative and non-legislative written and email correspondence and telephone calls. Develop and maintain Overviews of Medicaid Programs. Provide technical assistance to local and central eligibility staff; manage Income Trusts; manage New

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Eyes for the Needy Program; coordinate legal clarifications.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
| $2,887,512 | $1,443,756 | $1,443,756 | Yes | $0 | 51.00 |

**Expected Results:**

MEDS User Services staff provides support to more than 450 users. They are responsible for logging calls into a tracking database. On an average, they handle upwards of 700 "tickets" per month. Other MEDS User Services staff work with the MEDS contractor to develop system enhancements and resolve system problems. Interface staff resolve system generated alerts and work exception reports. They manually accrete beneficiaries to the state's Buy-In program when a condition exists that prevents the system from doing it automatically. The interface staff also provides customer service for beneficiaries who have concerns regarding their SSI Medicaid eligibility and premium payments. Beneficiary Services call center provides assistance to a population of over 800,000 Medicaid beneficiaries, of which 69,145 are enrolled into a managed care plan. The abandoned call rate is less than 10%. Enrollments and changes are processed accurately within 3 working days of receipt. Consistent and accurate application of policy and procedure by eligibility staff in accordance with State and federal regulations. Consistent and accurate application of policy and procedure by eligibility staff in accordance with State and federal regulations. Professional, friendly and accurate response to questions regarding eligibility.

**Outcome Measures:**

Help Desk reports are run periodically to determine timeliness standards. Almost 94% of calls are resolved within 1 day. Another report identifies why a call was made. The call description report is monitored as well. Other HD reports identify the number of outstanding calls or calls that have been closed within a certain time period. System enhancements are identified and placed on an enhancement spreadsheet and are monitored closely by agency and contractor staff bi-weekly. Enhancements are worked according to their priority level. Interface supervisors closely monitor alert activity to ensure alerts are handled in a timely manner. Each worker is responsible for resolving a particular type of alert. Buy-In manual accretions are performed by each staff member. The number of monthly accretions averages around 100. Beneficiary Services averaged 938 calls per day on the toll-free beneficiary line. Calls are monitored for quality by supervisor. Abandoned call rate averaged 11.5%. Beneficiary Services processed an average of 3,883 transactions monthly for an average 69,145 managed care members. 100% were keyed timely. Quality control error rates, Supervisory Case Reviews, training and technical assistance needs Quality control error rates, Supervisory Case Reviews, training and technical assistance needs Minimal complaints and dis-satisfied customers

**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

## 944 Automated Claims Processing

Medicaid claims are adjudicated and payment is made to the Medicaid provider of service for the enrolled recipient for which the service was performed. Medicaid Reporting: 1. MMIS Federal Reporting. Coordinate the submission of Medicaid statistical information related to payments and eligibles to CMS for inclusion in the national MMIS database. Coordinate the creation of data needed for the federal SCHIP reports that summarize SCHIP enrollment for SC. 2. Coordinate standardized agency reporting that includes data on payment, claims, beneficiaries, providers and services. These reports are produced on a predetermined schedule and are created based on the needs of management. 3. Coordinate procurement and installation of

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a Medicaid Decision Support System. This system will house all statistical information related to Medicaid and will be reported to management through a series of standard reports that will be coordinated with the chosen vendor. Federal SURS requirements will be met by this system. Medicaid Reporting: 1. MMIS Federal Reporting. Coordinate the submission of Medicaid statistical information related to payments and eligibles to CMS for inclusion in the national MMIS database. Coordinate the creation of data needed for the federal SCHIP reports that summarize SCHIP enrollment for SC. 2. Coordinate standardized agency reporting that includes data on payment, claims, beneficiaries, providers and services. 3. Coordinate procurement and installation of a Medicaid Decision Support System. This system will house all statistical information related to Medicaid and will be reported to management through a series of standard reports that will be coordinated with the chosen vendor. Federal SURS requirements will be met by this system. MMIS User Services 1. The Medicaid Management Information System is used to enroll providers, adjudicate claims, pay providers, report costs and utilization and enroll recipients into special programs. This department manages the development and maintenance of state policies, procedures and standards for the following: Pricing, procedures, provider enrollment, fund codes, edit codes. 2. Quarterly training is provided to agency staff concerning the Medicaid Management Information System.

**FY 2004-05**

| Total | General Funds | Federal Funds | FM | Other Funds | FTEs |
|---|---|---|---|---|---|
| $43,135,865 | $9,285,358 | $30,911,409 | Yes | $2,939,098 | 43.00 |

**Expected Results:**

Medicaid claims are expected to be processed in a timely and accurate manner. Medicaid providers of service are expected to be reimbursed for their services in a timely and accurate manner. 1. Policy and procedures are developed, updated and disseminated to staff. Updates to MMIS are made accurately and timely, within 10 working days of receipt of update form. 2. Staff take a pre-test prior to training and a post-test following training, and are expected to score higher on post test. Increased knowledge is expected to enhances staff's ability to carry out their job functions. 1. Policy and procedures are developed, updated and disseminated to staff. Updates to MMIS are made accurately and timely, within 10 working days of receipt of update form. 2. Staff take a pre-test prior to training and a post-test following training, and are expected to score higher on post test. Increased knowledge is expected to enhances staff's ability to carry out their job functions.

**Outcome Measures:**

Outcome measures are based on correctly processing claims and reimbursing providers. State Medicaid agencies are required to process claims within 30 days of receipt. 42CFR 447.45(d) cites the timely processing of claims rule. The actual average for processing a claim is less than 14 days. Electronic claims are processed in 10 calendar days or less. Paper claims are processed in 15 calendar days or less. The accuracy rate for each service is: Hospital 68.80%; Nursing Home Services 77.30%; Pharmacy Services 99.40%; Physician Services 76.64%; Dental Services 75.43%; CLTC 70.64%; Home Health Services 70.64%; EPSDT Screening 70.64%; Medical Professional Services 70.64%; Transportation Services 70.64%; Lab & X-ray Services 70.64%; Family Planning 88.86%; Hospice Care 70.64%; OSS 77.30%; IPC 77.30%; Clinic Services 70.64%; DME 70.64%; Managed Care 98.00%. 1. All data to this point has been validated, approved and included in the CMS databases within required time frames.2. Reports are produced timely to meet the needs of staff. 3. APD for development at 90% federal match was approved in May 2004. The RFP is in development. Total number of claims processed 35,160,972. MMIS User Services: 1. 207,482 procedure codes and associated pricing records; provider enrollment for 36,598 providers; fund code assignment for 494 fund codes; and approximately 600 edit codes used in claims processing are supported by the department of MMIS User Services. Policies and procedures were updated and disseminated to appropriate staff. 2. 156 employees participated in the MMIS training during a 12-month period, with 66 completing the 8 core courses and earning the MMIS training certificate. 94% of staff reported the training enhanced their job skills.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 945 Special Projects

Maybank money, Proviso 73.9: Healthcare Coordination and Utilization Project ($216,000), Columbia Urban League ($9,000), Greenville Urban League ($9000); Head Start ($200,000)

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $968,000 | $434,000 | $300,000 | Yes | $234,000 | 0.00 |

**Expected Results:**

**Outcome Measures:**

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 946 Audits/Compliance

Bureau of Compliance and Performance Review, with 3 divisions: Program Integrity, Audits, and SURS. Code of Federal Regulations (42 CFR 455.12 - 455.21) requires the state Medicaid agency to have methods and criteria for identifying suspected fraud cases. DHHS is required, upon suspicion of fraud or abuse on the part of a Medicaid beneficiary or provider, to conduct a preliminary investigation. Suspected fraud cases involving health care providers are required to be referred to the MFCU at the Attorney General's Office. The CFR as well as the State Medicaid plan set criteria for a Surveillance and Utilization Review System. The Division of Audits is responsible for monitoring compliance with Medicaid contracts. Eligibility Quality Assurance, also required under 42 CFR, monitors the accuracy of eligibility determinations; communicates findings to eligibility staff for corrective measures and reports error findings to Centers for Medicare and Medicaid Services on a semi-annual basis.

| | FY 2004-05 | | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $1,733,478 | $866,739 | $866,739 | Yes | $0 | 40.00 |

**Expected Results:**

Improved identification and increase in investigations of abusive and excessive Medicaid billings by health care providers; decrease in inappropriate use of Medicaid funds by state agencies; reduction in excessive and inappropriate use of prescription drugs and other benefits by Medicaid beneficiaries; development of a Medicaid payment accuracy rate. To determine the number and types of errors made by agency staff when determining initial and continuing eligibility; and to report error findings to the Centers for Medicare and Medicaid Services and agency management.

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**Outcome Measures:**

Amount Medicaid funds recouped from abusive and excessive providers - a 10% increase would amount to $8.8 million;cost savings of $500,000 due to beneficiary utilization program; 10% increase in number of fraud cases referred to MFCU; development of audit standards in accordance with US General Accounting Office; 20% increase in audit recommendations with follow-up of impact. To assist DHHS' management and eligibility staff in the identification of problems within the eligibility determination process and to develop corrective action plans to ensure accuracy.

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 947 Internal Information Technology

Support agency information technology; Information Technology Helpdesk; PC Software applications; Document imaging; Network support

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $3,291,320 | $1,645,660 | $1,645,660 | Yes | $0 | 24.00 |

**Expected Results:**

Agency information technology infrastructure available 24/7; Helpdesk staff respond to request within reasonable time; Applications developed on time and meet requirements; Documents are imaged timely; Network infrastructure availability 24/7

**Outcome Measures:**

Information technology availability; Average respond time for like request; Duration of development in days and user satisfaction; Imaging staff average 125 files per day; Network availability percentage

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**Agency:** J02 - Health & Human Services Finance Commission

**Functional Group:** Health

### 948 Agency Administration

Agency administration includes Financial Management, Rate Setting, Human Resources, Public Information, Procurement and Support Services, Civil Rights Management, Contracts Management,Appeals and Hearings, Security and Building Maintenance, and Legal Services. Financial Management develops, implements, and manages the agency budget; directs all aspects of the agency's financial accounting operations; provides financial and fiscal impact analysis and consultation on Medicaid issues agency director, staff, Governor's Office, General Assembly, State Budget Office, and other external entities. Rate Setting develops and adjusts reimbursement rates for health care providers. Human Resources manages the personnel functions of the agency in the areas of classification, compensation, recruitment, benefits, employee relations, training, and development. Public Information provides answers to questions presented to the agency by the general public,

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the news media, and elected officials. It provides legislative liaison, assures agency compliance with the Freedom of Information Act, and helps the agency meet federal mandates that all Medicaid policy changes receive a recommendation from the South Carolina Medical Care Advisory Committee. It accomplishes its activities in person, over the telephone, by letter, through the news media, and via the Internet. Procurement and Support Services: Responsible for coordinating and evaluating procurements and contractual arrangements for the agency. Administers the agency policies related to postal, supply, fleet, and property management. Contracts Management: Directs the solicitation, development and management of contracts and memorandums of agreement for Aging and Medicaid Services that legally bind DHHS and the provider based upon state and federal regulations. Appeals and Hearings: To provide fair hearings to Medicaid applicants and recipients who have received a negative decision from the Department that they believe is the result of error of fact or law. Provides fair hearings to providers who have a dispute with the Department over payment of claims, contract termination, nursing home reimbursement rates, etc. Provides fair hearings to any resident of a Title XIX facility that has proposed transfer or discharge of the resident.

| | | FY 2004-05 | | | |
|---|---|---|---|---|---|
| **Total** | **General Funds** | **Federal Funds** | **FM** | **Other Funds** | **FTEs** |
| $10,566,106 | $1,946,246 | $7,730,348 | Yes | $889,512 | 119.75 |

**Expected Results:**

The agency maintains appropriate levels of accountability and control over it's financial assets, pays bills promptly, and complies with applicable laws, regulations and policies. Prompt and accurate responses to financial data requests provided in a clear and understandable format. Rate Setting: (1) - To develop fair and equitable Medicaid reimbursement rates for all non-institutional Medicaid services based upon a federally approved rate setting methodology, as well as review budgets for agency administrative contracts for compliance with state and federal regulations concerning allowable costs. (2) - To oversee the development of fair and equitable Medicaid reimbursement methodologies that adequately reimburses Medicaid providers, comply with applicable state and federal regulations, and limit expenditures within the appropriated dollars. Human Resources complies with all State and Federal human resources laws and regulations. Based upon FY 2003-04 activities, expected results in this fiscal year are: 1,600 Web-based questions received from the public; 31 FOIA notices of agency meetings issued; 163 FOIA letters received and responded; 12 legal ads placed in compliance with federal regulations; 180 media calls handled by the staff; 1,230 public calls handled by the staff; 20 press releases issued; 238 legislative affairs constituent issues received and answered; 48 packages of news articles circulated electronically to internal/external audience; 2nesletters coordinated for Medicaid beneficiaries; 130 requests from legislative staff were received and responded. Procurement and Support Services: Procurements will be completed in accordance with SC Consolidated Procurement Code. Accountability of property management, postal, fleet and supply is ensured. Contracts Management: Medicaid contracts are completed based upon the SC Consolidated Procurement Code, state and federal regulations. Appeals and Hearings: To provide fair hearings in accordance with the federal and state laws and regulations and to render decisions based on the facts and applicable law/policy outcome to ensure eligible citizens receive the services they are entitled to and providers are reimbursed correctly.

**Outcome Measures:**

Financial Management ends fiscal year within available resources and without major audit findings. Processed 1,664 contracts, 3,978 purchase requisitions, and 945,000 accounting transactions processed. Rate Setting(1) Reviewed 373 various FY end cost reports of various provider types to determine the aggregate annual cost increase incurred by certain provider groups participating in the SC Medicaid Program, as well as determine updated Medicaid rates and appropriate Medicaid reimbursement for FQHCs, Group Homes, State Agencies, and other Behavioral Health Services. Additionally, 297 RHC and Home Health cost reports were reviewed to establish updated Medicaid rates and proper Medicaid reimbursement based upon Medicare rate information. Lastly, 239 contract budget checklists were reviewed to ensure that costs claimed for reimbursement were allowable in accordance with state and federal regulations. (2) - All state plan amendments submitted by the

# Agency Activity Inventory
## by Agency
## Appropriation Period: FY 2004-05

Bureau of Reimbursement Methodology and Policy were approved by CMS with an October 1, 2003 effective date. Processed approximately one hundred twenty (120) pay actions and sixty (60) reclassifications. • Began coordinating and sending over 300 supervisors to a 4-day intensive supervisory training session contracted through the Budget and Control Board. The information needs of elected officials, the media, and the public were received and responded to without complaint. The agency was in compliance with the state's Freedom of Information Act regarding public notice of its activities and met federal requirements for Medical Care Advisory Committee review of its programmatic policy changes. Developing a newsletter for Medicaid beneficiaries allowed the agency to combine rule changes, education on Medicaid requirements, and useful disease management information in one mailing, thereby saving postage costs. Procurement and Support Services: Property management, postal, fleet management and supply services will be operated in accordance with established procedures and regulations. Contracts Management: Medicaid Services are available to Medicaid beneficiaries. DHHS has data related to Aging and Medicaid programs and services. Appeals and Hearings: To provide fair hearings in accordance with the federal and state laws and regulations and to render decisions based on the facts and applicable law/policy outcome to ensure eligible citizens receive the services they are entitled to and providers are reimbursed correctly.

## AGENCY TOTALS

*Health & Human Services Finance Commission*

| TOTAL AGENCY FUNDS | TOTAL GENERAL FUNDS | TOTAL FEDERAL FUNDS | TOTAL OTHER FUNDS | TOTAL FTEs |
|---|---|---|---|---|
| $4,311,314,632 | $722,163,147 | $2,962,600,047 | $626,551,438 | 1,143.52 |